Senate

General Assembly

File No. 233

January Session, 2007

Substitute Senate Bill No. 1371

Senate, April 2, 2007

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT ESTABLISHING THE CONNECTICUT SAVES HEALTH CARE PROGRAM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective from passage*) As used in sections 1 to 10, inclusive, of this act:

(1) "Policy" means a health insurance policy as described in section 4 of this act.

(2) "Commission" means the Connecticut Saves Health Care Commission established under section 2 of this act.

(3) "Eligible individual" means an individual who is (A) a resident of the state, and (B) under sixty-five years of age, except that "eligible individual" does not include an individual who has been a resident of the state for less than six consecutive months prior to the date of application for such program.

(4) "Program" means the Connecticut Saves Health Care program.

Sec. 2. (*Effective from passage*) (a) There is established the Connecticut Saves Health Care Commission to implement and administer the Connecticut Saves Health Care program.

(b) The commission shall consist of the following members:

(1) Two appointed by the speaker of the House of Representatives;

(2) Two appointed by the president pro tempore of the Senate;

(3) One appointed by the majority leader of the House of Representatives;

(4) One appointed by the majority leader of the Senate;

(5) One appointed by the minority leader of the House of Representatives;

(6) One appointed by the minority leader of the Senate;

(7) One each appointed by the chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to insurance; and

(8) Two appointed by the Governor.

(c) Any member of the commission appointed under subdivision (1), (2), (3), (4), (5), (6) or (7) of subsection (b) of this section may be a member of the General Assembly.

(d) All appointments to the commission shall be made not later than July 1, 2007. Each member shall serve for a term of three years and no member shall serve for more than two consecutive terms. Any vacancy shall be filled by the appointing authority.

(e) The speaker of the House of Representatives and the president pro tempore of the Senate shall select the chairpersons of the commission from among the members of the commission. Such chairpersons shall schedule the first meeting of the commission, which

shall be held not later than sixty days after the effective date of this section.

(f) Not later than January 1, 2008, and annually thereafter, the commission shall submit a report on its findings and recommendations to the joint standing committees of the General Assembly having cognizance of matters relating to insurance, human services and public health, in accordance with the provisions of section 11-4a of the general statutes. Such report shall address the progress in implementing the program and include any modifications in employer or resident contribution levels or state-funding levels.

Sec. 3. (NEW) (*Effective from passage*) (a) There is established the Connecticut Saves Health Care program to provide health insurance policies, as defined in section 38a-469 of the general statutes, to ensure affordable health care for eligible individuals.

(b) The commission shall arrange and procure health insurance policies for enrollees in the program. The commission shall negotiate and contract with insurance companies and health care centers authorized to do insurance business in the state, in accordance with the provisions of section 38a-41 of the general statutes, to provide health insurance policies to the program. Such health insurance policies shall be approved by the Insurance Commissioner in accordance with the provisions of title 38a of the general statutes. The commission shall:

(1) Determine covered benefits and out-of-pocket cost-sharing to assure affordable access to necessary health care;

(2) Survey employer-based health coverage in New England to assist in determining such benefits and cost-sharing;

(3) Reimburse health care providers;

(4) Credential health care providers for participation in the program;

(5) Issue or arrange for the issuance of the same Connecticut Saves

card to all enrollees in the program;

(6) Improve quality of care through measures that include, but are not limited to:

(A) Obtaining and publishing data pertinent to quality of care,

(B) Encouraging the development of integrated health care systems, incorporating such procedures as case management, registries, feedback to physicians and team-based approach to patient-centered care, and

(C) Preventing and managing of chronic disease;

(7) Reduce unnecessary health care spending and control health care cost growth through measures that include, but are not limited to:

(A) Administrative simplification;

(B) Provider reimbursement policies;

(C) Prevention and management of chronic disease;

(D) Consumer quality report cards;

(E) Error reporting;

(F) Strengthening certificate of need procedures; and

(G) E-health initiatives;

(8) Devise and implement systems for voluntary and automatic enrollment;

(9) Establish and implement policies and procedures for interstate coverage issues involving state residents who work or receive health care in other states and residents of other states who work or receive health care in this state;

(10) Establish arrangements with the Department of Revenue

Services through which employers and state residents have their contributions sent automatically to said department, via payroll withholding or otherwise, which in turn provides those contributions to the Comptroller; and

(11) Educate state residents concerning the use of the program, the importance of preventive care and assessments, and communicate general public health messages.

(c) The commission may delegate the duties of reimbursing and credentialing health care providers and preventing and managing chronic disease to a third-party administrator.

(d) The commission shall educate state residents about the health insurance policies available under the program, by means including, but not limited to, preparation of educational materials; conducting informational sessions or workshops; contracting with nonprofit organizations and community-based organizations for outreach to hard-to-reach populations and training, consulting with and reimbursing licensed health insurance brokers for assistance in educating residents.

(e) The commission shall promote the use of information technology by insurance companies and health care centers providing health insurance policies to the program, individuals applying to, enrolled in or seeking information about the program and persons providing information to the program and shall arrange for the provision of technical support, training and assistance to assure the effective use of such information technology. The commission shall require each insurance company and health care center providing health insurance policies to the program to operate an electronic health record system not later than October 1, 2007, certified by the commission, that meets interoperability standards established by the commission, by regulations adopted in accordance with subsection (f) of this section, for such electronic health record systems.

(f) The commission shall adopt regulations, in accordance with

chapter 54 of the general statutes, to implement and administer the Connecticut Saves Health Care program pursuant to sections 1 to 10, inclusive, of this act.

Sec. 4. (NEW) (*Effective from passage*) (a) The commission shall make available to each eligible individual seeking enrollment in the program a health insurance policy, affordable to most state residents, offering the benefits specified in subdivision (2) of subsection (b) of this section. The commission shall survey employer-based health insurance coverage in New England to determine the actuarial value of policy coverage.

(b) The policy shall:

(1) Have an actuarial value that is not less than the sum of (A) the actuarial value of all coverage, excluding dental coverage, for average New England enrollees in employer-based insurance during the previous year; and (B) the actuarial value of dental coverage for average New England enrollees in employer-based insurance during the previous year; and

(2) Offer benefits including, but not limited to, office visits, inpatient and outpatient hospital care, mental and behavioral health care, including substance abuse treatment, prescription drugs, including brand name and generic drugs, maternity care, including prenatal and postpartum care, oral contraceptives, durable medical equipment, speech, physical and occupational therapy, home health care, hospice services and extended care as alternatives to institutionalization; preventive and restorative dental care, basic vision care and, as prescribed by a physician, personalized nutrition and exercise plans and smoking cessation services; examinations, screenings, and immunizations for every adult and child including, but not limited to, well-child and well-baby care, which shall be exempt from out-of-pocket cost-sharing.

Sec. 5. (NEW) (*Effective from passage*) (a) The commission shall prospectively adjust payments for each health insurance policy under

the program to compensate fully for any differences between the average risk levels of the policy's enrollees and the state's nonelderly population.

(b) Within available appropriations, during the first three years of implementation of the program, the commission may subsidize the cost of reinsurance premiums related to the program. The remainder of the cost of such premiums shall be paid from payments made to the program by or on behalf of enrollees.

(c) The commission shall establish risk corridors and coinsurance percentages for subsidized reinsurance based on best practices from other states.

(d) On or before January 1, 2011, the commission shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance and real estate, containing recommendations about future financing for reinsurance. If the General Assembly does not take action to the contrary before the end of the February, 2012 regular session, reinsurance premiums shall, for the third and each subsequent year, be paid entirely by payments made to the program by or on behalf of enrollees.

Sec. 6. (NEW) (*Effective from passage*) (a) Any state resident may purchase health insurance coverage under the program at the full cost for such coverage, as determined by the commission, if such resident is sixty-five years of age or older and is employed by, or whose spouse is employed by, an employer that: (1) Offered employer-sponsored insurance on or before October 1, 2006, but no longer offers such insurance, and (2) would have qualified to participate in such employer-sponsored insurance in effect on October 1, 2006.

(b) Any employer may purchase either full or partial coverage under the program for a retired employee who is a state resident at the full cost for such coverage, as determined by the Comptroller.

Sec. 7. (NEW) (*Effective from passage*) On and after July 1, 2008, any eligible individual, or individual purchasing coverage in the program in accordance with the provisions of section 6 of this act, may apply to the program through the commission or the Department of Social Services.

Sec. 8. (NEW) (*Effective from passage*) On and after July 1, 2008, an eligible individual not yet enrolled in the program shall be enrolled by default when any of the following occurs:

(1) Such individual's income is reported to the Department of Revenue Services or the Labor Department;

(2) A state income tax form is filed on which such individual is listed as a member of the household; or

(3) Such individual seeks health care.

Sec. 9. (NEW) (*Effective from passage*) (a) The Department of Social Services shall screen each eligible individual, or individual purchasing coverage in the program in accordance with the provisions of section 6 of this act, at the time such individual applies for the program for eligibility under Title XIX or Title XXI of the Social Security Act. Such screening shall also determine income for purposes of establishing the amount of premium payments under the program for each such individual. Individuals shall be enrolled in the appropriate state Medicaid program or the HUSKY Plan, unless the individual objects to such enrollment. To the maximum extent feasible, relevant information shall be obtained through state-maintained or state-accessible data and through the self-attestation of individuals.

(b) Notwithstanding any provision of the general statutes, the following information shall be made available to the Department of Social Services and the Comptroller for the purposes of determining eligibility under Title XIX or Title XXI of the Social Security Act and for establishing premium payments under the program:

(1) Eligibility and enrollment information for individuals enrolled in

means tested assistance programs, other then the HUSKY Plan;

(2) New hire information and quarterly reports provided to the Labor Department;

(3) State income tax information maintained by the Department of Revenue Services;

(4) Information showing United States citizenship of individuals, including, but not limited to, information obtained from birth certificates and other vital records; and

(5) Federal information about new hires, quarterly earnings, Social Security numbers, immigration status and other data pertinent to income or other components of eligibility for Title XIX or XXI of the Social Security Act.

(c) The Comptroller and the Commissioner of Social Services shall enter into agreements with other state agencies providing or receiving information for the program. Such agreements shall require that:

(1) Such information be used only to verify or establish income or eligibility for matching funds under Titles XIX or XXI of the Social Security Act; and

(2) Each state agency providing information to the program train and monitor all staff and contractors who have access to such information and inform such staff and contractors of all applicable state and federal privacy and data security requirements.

(d) Within available appropriations, the Commissioner of Social Services shall develop and operate the information infrastructure required to conduct the screening described in subsection (a) of this section and shall take all feasible steps to maximize the use of federal funds for developing and operating such infrastructure. The commissioner, in consultation with data privacy and security experts, shall develop and implement policies and procedures that maintain data security and prevent inadvertent, improper and unauthorized

access to or disclosure, inspection, use or modification of information.

(e) Any individual about whom information is provided to the program shall have the right to (1) obtain, at no cost to the individual, a copy of all such information, which shall identify the agency from which the information was obtained, and (2) correct any misinformation or complete any incomplete information. If any breach of an individual's privacy occurs, such individual shall be promptly informed of such breach and of any rights and remedies available to the individual as a result of such breach.

Sec. 10. (NEW) (*Effective from passage*) (a) On or before January 1, 2008, the Commissioner of Social Services shall submit to the federal Centers for Medicare and Medicaid Services an amendment to the state Medicaid plan required by Title XIX of the Social Security Act to extend coverage to all parents, guardians and caretaker relatives with incomes at or below three hundred per cent of the federal poverty level, as well as to any other individuals with incomes below such level who are nineteen to sixty-four years of age, inclusive, and who may be covered, at state option, through the state plan amendment.

(b) If needed to access all federal funds allotted to the state under Title XXI of the Social Security Act, the commissioner shall cover individuals over eighteen years of age, including, but not limited to, pregnant women, whether or not such individuals are eligible for coverage under Title XIX of the Social Security Act.

(c) (1) On or before January 1, 2008, the commissioner shall submit an application for a waiver under Section 1115 of the Social Security Act, in accordance with section 17b-8 of the general statutes, to authorize the use of funds received under Title XXI of the Social Security Act for individuals nineteen to sixty-four years of age, inclusive, with incomes at or below one hundred eighty-five per cent of the federal poverty level who do not otherwise qualify under Title XIX of the Social Security Act, either under mandatory eligibility or at state option through state plan amendment. Federal budget neutrality requirements for such waiver may be met through unused

uncompensated care payments to hospitals or by taking other measures, provided such measures do not result in any of the following for individuals who would have qualified for coverage under the Medicaid program, the HUSKY Plan or state-administered general assistance:

(A) Any reduction in covered services or access to care;

(B) Any increase in deductibles, premiums or other out-of-pocket costs; or

(C) Any reduction in enforceable, individual guarantees of coverage or services.

(2) If federal budget neutrality requirements do not permit extending Title XIX coverage to the individuals described in subdivision (1) of this subsection, such coverage shall extend to such individuals with incomes under the highest possible percentage of federal poverty level less than one hundred eighty-five per cent.

Sec. 11. (NEW) (*Effective from passage*) On or before September 1, 2009, the Department of Public Health shall expand the state's network of school-based health clinics so that all public school children in the state have ready access to such clinics. Such school-based health clinics shall be licensed by said department pursuant to chapter 368v of the general statutes and shall provide physical and behavioral health care, including dental care, with appropriate linkages to other services in the state. Such services shall include, but not be limited to, local health departments, community health centers, hospitals, social service providers, mental health and family service agencies, youth service bureaus, pediatricians and other primary care physicians and adolescent medical specialists.

Sec. 12. (NEW) (*Effective from passage*) (a) On or before July 1, 2009, the Department of Public Health shall establish sufficient primary care clinics to supplement other primary care resources so that all state residents shall have ready access to necessary primary care. Such

primary care clinics shall be licensed by said department pursuant to chapter 368v of the general statutes and provide physical and behavioral health care, including dental care, with appropriate linkages to other services in the state, including, but not limited to, specialty care providers, other primary care providers and pharmacies. Each primary care clinic shall be, or be operated by, a federally qualified health center, a health center determined by the Commissioner of Public Health to be substantially similar to a federally qualified health center or a hospital. Each primary care clinic shall provide a wide range of primary care services and shall remain open outside of normal business hours to provide access to urgent but nonemergency care.

(b) Licensed physicians and other health care providers who provide their services for a minimum number of hours to primary care clinics at a reduced rate shall receive incentives that may include, but need not be limited to, reduced cost medical malpractice insurance offered or arranged by the Department of Public Health, loan forgiveness from postsecondary educational institutions that receive funding from the state and partial payment of educational loans.

Sec. 13. (NEW) (*Effective from passage*) The Commissioner of Public Health shall adopt regulations, in accordance with chapter 54 of the general statutes, to implement the provisions of sections 11 and 12 of this act and to establish requirements for: (1) Services to be provided by and the hours of operation of primary care clinics; and (2) the provisions of services to primary care clinics by physicians and other health care providers, including the number of hours such services shall be provided.

Sec. 14. (NEW) (*Effective from passage*) (a) On or before January 1, 2008, and biennially thereafter, the Department of Public Health shall publish Plans For A Healthy Connecticut. The department shall develop each such plan with the assistance of state and local agencies, health care experts and members of the public. Each such plan shall include, but not be limited to, information pertaining to the following:

(1) Access to essential health care;

(2) Health care quality;

(3) Health care costs;

(4) Data collection and analysis needs;

(5) Health status and health care disparities, including those based on race, ethnicity, gender, age, sexual orientation, area of residence, health status, diagnosis, immigration status, education, employment, English-language fluency and other relevant factors between different groups of Connecticut residents; and

(6) Preservation of wellness and prevention of health problems.

(b) For each item listed in subsection (a) of this section, and for any other items included in the plan, the plan shall include:

(1) An assessment of the current status of such item in Connecticut;

(2) An analysis of recent public and private efforts to address such item;

(3) Recommendations for future public and private actions to address such item; and

(4) A statement of measurable goals and objectives, with defined time frames, that reasonably can be achieved given sufficient public and private sector commitment and resources.

Sec. 15. (*Effective from passage*) (a) There is established a Blue Ribbon Commission to study the Connecticut Saves Health Care program. Such study shall include, but not be limited to, an examination of the effect of such program on the cost of providing medical care in the state and the accessibility to medical care for residents of the state. Such commission shall develop recommendations for applying aspects of the program to the state residents who are served by the Medicare program.

(b) The commission shall consist of the following members:

(1) One each to be appointed by the Governor, the speaker of the House of Representatives, the president pro tempore of the Senate, the majority leader of the House of Representatives, the majority leader of the Senate, the minority leader of the House of Representatives and the minority leader of the Senate;.

(2) The Commissioner of Social Services, or said commissioner's designee; and

(3) The Comptroller, or said Comptroller's designee.

(c) Any member of the commission appointed under subdivision (1) of subsection (b) of this section may be a member of the General Assembly.

(d) All appointments to commission shall be made no later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(e) The member appointed by the Governor shall be the chairperson of the commission. The chairperson shall schedule the first meeting of the commission, which shall be held no later than sixty days after the effective date of this section.

(f) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to insurance shall serve as administrative staff of the commission.

(g) Not later than January 30, 2008, the commission shall submit a report on its findings and recommendations to the joint standing committees of the General Assembly having cognizance of matters relating to human services and public health, in accordance with the provisions of section 11-4a of the general statutes. The commission shall terminate on the date that it submits such report or January 30, 2008, whichever is later.

Sec. 16. (*Effective July 1, 2007*) An amount is appropriated to the Connecticut Saves Health Care Commission, from the General Fund, for the fiscal year ending June 30, 2008, for implementation of the Connecticut Saves Health Care program, established under section 3 of this act.

Sec. 17. (*Effective July 1, 2007*) An amount is appropriated to the Connecticut Saves Health Care Commission, from the General Fund, for the fiscal year ending June 30, 2008, for the purpose of lowering, by not less than ten per cent, the cost to employers of having employees and dependents receive health insurance coverage through the Connecticut Saves Health Care program, established under section 3 of this act.

Sec. 18. (*Effective July 1, 2007*) An amount is appropriated to the Connecticut Saves Health Care Commission, from the General Fund, for the fiscal year ending June 30, 2008, for payment of reinsurance premiums for the Connecticut Saves Health Care program, established under section 3 of this act.

Sec. 19. (*Effective July 1, 2007*) An amount is appropriated to the Department of Social Services, from the General Fund, for the fiscal year ending June 30, 2008, to develop and operate the information technology infrastructure required under section 9 of this act.

Sec. 20. (*Effective July 1, 2007*) An amount is appropriated to the Department of Public Health, from the General Fund, for the fiscal year ending June 30, 2008, for the purpose of expanding the state's network of school-based health clinics, in accordance with section 11 of this act.

Sec. 21. (*Effective July 1, 2007*) An amount is appropriated to the Department of Public Health, from the General Fund, for the fiscal year ending June 30, 2008, for the purpose of establishing primary care clinics, in accordance with section 12 of this act.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	New section
Sec. 2	*from passage*	New section
Sec. 3	*from passage*	New section
Sec. 4	*from passage*	New section
Sec. 5	*from passage*	New section
Sec. 6	*from passage*	New section
Sec. 7	*from passage*	New section
Sec. 8	*from passage*	New section
Sec. 9	*from passage*	New section
Sec. 10	*from passage*	New section
Sec. 11	*from passage*	New section
Sec. 12	*from passage*	New section
Sec. 13	*from passage*	New section
Sec. 14	*from passage*	New section
Sec. 15	*from passage*	New section
Sec. 16	*July 1, 2007*	New section
Sec. 17	*July 1, 2007*	New section
Sec. 18	*July 1, 2007*	New section
Sec. 19	*July 1, 2007*	New section
Sec. 20	*July 1, 2007*	New section
Sec. 21	*July 1, 2007*	New section

INS *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either chamber thereof for any purpose:

OFA Fiscal Note

State Impact: See below

Municipal Impact: See below

Explanation

This bill makes various changes to the health care system in Connecticut. Due to various internal incongruities, a determination of the fiscal impact of the bill is not possible.

Sections 1 through 8 of the bill establish the Connecticut Saves Health Care Commission to implement and administer the Connecticut Saves Health Care (CSHC) program. The commission must arrange and procure health insurance policies for enrollees in CSHC, negotiate and contract with insurers, determine benefits and cost sharing, reimburse providers, and credential providers. Although the bill allows the commission to delegate the reimbursement, credentialing and certain disease management functions to third party administrators, the bill does not provide the commission with staff to perform any the of commission's other responsibilities. As the bill does not place the commission within any state agency for administrative purposes, it is unclear how the commission, which is composed of 12 appointed (and apparently uncompensated) members, can carry out the responsibilities detailed in the bill.

This commission must establish arrangements with the Department of Revenue Services to have employer and individual contributions to pay for benefits sent automatically to the department, which will then turn the contributions over to the Comptroller. Depending upon the collection mechanisms, these agencies would incur administrative costs. It is unclear what the Comptroller's subsequent responsibilities are, as the bill requires the commission to make payments to reimburse

health care providers.

The health insurance policies developed by the commission must be actuarially equivalent to the average employer sponsored insurance policy in New England. The bill allows the commission to subsidize reinsurance and establish risk corridors to lower the cost of premiums. As the bill does not specify the amount appropriated to the commission for this purpose, the fiscal impact cannot be known.

Section 8 of the bill requires that, on or after July 1, 2008, any eligible individual shall be enrolled in CSHC by default when certain actions take place. Eligible individuals are any state resident under the age of 65. There are approximately 2.95 million such individuals in Connecticut. The bill requires the commission to procure insurance policies for enrollees in the program. Assuming that health insurance policies procured under the terms of the bill would cost between $4,000 and $6,000 annually, the total cost of the policies would be between $11,800,000,000 and $17,700,000,000. As the premiums and cost sharing is to be determined by the commission, the net state cost of this provision is not known.

Under the bill, currently insured individuals would be enrolled in this program. This would include all state and municipal employees under the age of 65. It is unclear how this enrollment would comply with current collective bargaining agreements. The bill also does not exempt individuals currently eligible for Medicaid benefits from this default enrollment. As federal law requires that Medicaid be the payer of last resort, CSHC would thus pick up the cost of services for all HUSKY A and B members, as well as those Medicaid fee-for-service enrollees under the age of 65. The state would therefore lose the 50% federal match (65% for HUSKY B) for the cost of these services. Medicaid may then serve as a wrap around policy for services available under the Medicaid program but which are not included in the CSHC plan.

Section 9 of the bill requires the Department of Social Services (DSS) to screen every eligible individual for Medicaid eligibility. Given that

approximately 2.95 million residents are eligible for this program, DSS would incur considerable administrative staff costs for this screening.

This section also requires each state agency providing information required in the bill to train and monitor all staff and contractors who have access to the information. This will result in increased costs to all such agencies. The extent of these costs will be dependent upon the level of training and monitoring necessary to meet the privacy and security requirements.

This section also requires DSS to develop and operate the information infrastructure required by the bill, within available appropriations. The bill provides no such appropriations.

Section 10 implements several expansions of eligibility for the HUSKY program. Given the default enrollment of HUSKY clients in the CSHC plan implemented in section 8 of this bill, the implications of these expansions are not clear.

Section 11 requires the Department of Public Health to expand school based health centers (SBHC's) to ensure access to all public school children, on or before 9/1/09. These clinics must provide physical, dental and behavioral health care. A significant cost will be incurred by the DPH to comply with this mandate.

While **Section 20** appropriates an amount (unspecified) to DPH in FY 08 for this purpose, no funding has been included within the Governor's recommended FY 08 budget to expand SBHC's[1].

SBHC services are currently available in 72 schools within Connecticut. Establishing a comprehensive SBHC, with dental care, in each of the remaining 1,008 public schools would result in a state expense of approximately $356,000,000, based upon a 75%[2] state

[1] $7,709,364 is recommended for grants to existing school based health centers, located in about 20 communities. An additional approximate $290,000 in federal funding is provided to SBHCs annually.

[2] As recommended by the SBCH Ad Hoc Committee to Improve Health Care Access. Of the 19,881 children who utilized SBHC services in FY 05, 44% were enrolled in

contribution and operation on a school-year basis. This would rise to $391,000,000 if services were available throughout the year[3]. In practice, however, costs would be mitigated as many school districts are not able to accommodate SBHC's within their present building capacity. Future indeterminate capital costs would be incurred to provide needed space.

An additional estimated state cost of $17,400,000 would be incurred to enhance service delivery at existing sites to the comprehensive SBHC-model standard of care. Further significant costs would be associated with supporting additional regulatory, program, fiscal and administrative staff required to implement the program expansion.

To the extent that increased services lead to enhanced billings to the HUSKY programs, DSS will experience increased utilization and corresponding increases in costs. However, these costs would be partially mitigated to extent that the use of higher cost medical care is averted. Studies have shown that use of SBHC services leads to reduced emergency department visits, and reduced Medicaid expenditures related to inpatient care and pharmaceutical use.

Section 12 requires the Department of Public Health to establish sufficient primary care clinics to ensure access to all state residents. The primary care clinics must be licensed and provide physical and behavioral health care, including dental care, and urgent but non-emergency care. A significant cost will be incurred by the DPH to comply with this mandate.

While **Section 21** appropriates an amount (unspecified) to DPH in FY 08 for this purpose, no primary care clinic expansion funding has been included within the Governor's recommended FY 08 budget. However, $25.8 million in bond funds were allocated in October 2006

Medicaid, 29% had no health insurance, 26% were privately insured and 1% had unkown insured status. SBHC's have experienced significant challenges related to billing third party insurers, including Medicaid.

to expand medical and dental facilities at the state's thirteen Community Health Centers (CHC's).[4]

Of those health care facilities regulated by the department, CHC's[5] provide services most closely aligned with those described in Section 12(a). The average annual cost of operating a CHC is estimated at $8,000,000. One medically underserved area[6] in Connecticut is presently without federally qualified health center (FQHC) or FQHC look-alike services. Establishing a new CHC would require an indeterminate significant capital investment. An additional significant cost would be incurred by the department should it provide an operating subsidy comparable to that historically provided to other CHC's[7]

Section 12(b) requires the DPH to arrange for or offer incentives to certain health care providers serving primary care clinics. Associated costs would depend upon the types of incentives offered and the number of participating providers, which cannot be determined in advance. For comparison purposes, the DPH currently oversees a State Loan Repayment Program, under which awards of up to $30,000 are made to primary care providers who commit to provide full-time clinical services for a period of two years. The program currently has 21 participants, with available funding for 7 additional professionals.

To the extent that increased services lead to enhanced billings to the medical assistance programs operated by the Department of Social Services, the department will experience increased utilization and corresponding increases in costs. However, these costs would be

[3] Per the Report of the SBHC Ad Hoc Committee (December 2006), the cost of operating a comprehensive SBHC, including dental care, on a school year basis is $471,603; this rises to $517,727 on a full-year basis.
[4] CHC's provide services at over 80 locations across the state.
[5] Licensed as outpatient clinics.
[6] As defined by the federal government for purposes of determining eligibility to receive grants under Section 330 of the Public Health Service Act. The community is Danbury.
[7] In FY 07, the DPH provided the thirteen CHC's operating subsidies ranging from $102,974 to $925,829 (average $387,055).

partially mitigated to extent that the use of higher cost medical care is averted due to greater utilization of preventative health care.

Section 13 requires the Department of Public Health to adopt regulations to implement Sections 11 and 12 and establish requirements for primary care clinics. The agency can do within its normally budgeted resources.

Section 14 requires the Department of Public Health to publish "Plans for a Healthy Connecticut" by 1/1/08 and biennially thereafter. The department will incur an FY 08 cost of $147,000 to support the salaries of one Principal Health Care Analyst and one Lead Planning Analyst needed to compile data needed for this report, as well as associated other expenses and equipment Ongoing costs of $142,500 in FY 09 and subsequent years would be associated with this staffing expansion.

Additional fringe benefits costs of $48,160 in FY 08 and $84,280 in FY 09 would also be incurred.[8]

Section 15 creates a Blue Ribbon Commission to study the new CSHC program. The committee must report its finding to the General Assembly by January 30, 2008. The staff of the legislative Insurance and Real Estate committee shall serve as administrative staff. The legislature and any department whose personnel may be appointed to the Commission will incur minimal administrative expenses.

Sections 16 through 21 make various unspecified appropriations. As no funds are actually appropriated, these sections have no fiscal

[8] The fringe benefit costs for state employees are budgeted centrally in the Miscellaneous Accounts administered by the Comptroller. The estimated first year fringe benefit rate for a new employee as a percentage of average salary is 25.8%, effective July 1, 2006. The first year fringe benefit costs for new positions do not include pension costs. The state's pension contribution is based upon the prior year's certification by the actuary for the State Employees Retirement System (SERS). The SERS 2006-07 fringe benefit rate is 34.4%, which when combined with the non pension fringe benefit rate totals 60.2%.

impact.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

sSB 1371

AN ACT ESTABLISHING THE CONNECTICUT SAVES HEALTH CARE PROGRAM.

SUMMARY:

This bill establishes the Connecticut Saves Health Care Commission and program. It requires the commission to provide affordable health insurance policies to certain state residents, determine covered benefits and cost-sharing requirements, set terms for reinsurance coverage, improve quality of care, reduce health care spending, establish enrollment and premium collection procedures, educate residents on the program and important public health matters, promote information technology use, and adopt regulations. It creates a Blue Ribbon Commission to evaluate the program and report to the legislature.

It requires the Department of Social Services (DSS) commissioner to (1) screen every program-eligible person for HUSKY eligibility and (2) apply for a Medicaid waiver to use federal funds for certain individuals not currently HUSKY eligible. The bill increases HUSKY income eligibility limits.

The bill requires the Department of Public Health (DPH) to expand the state's network of school-based health clinics (SBHCs), establish primary care clinics, adopt regulations regarding the SBHCs and clinics, and publish "Plans for a Healthy Connecticut."

It makes numerous appropriations in unspecified amounts from the General Fund for FY 08 to implement the bill's requirements.

EFFECTIVE DATE: Upon passage, except for the appropriations, which are effective July 1, 2007.

CONNECTICUT SAVES HEALTH CARE

The bill establishes a 12-member Connecticut Saves Health Care Commission ("commission") to implement and administer the Connecticut Saves Health Care program ("program") to provide affordable health insurance policies to eligible people. The insurance commissioner must approve the policies.

Commission Membership and Reporting (§ 2)

The bill requires member appointments by July 1, 2007, as follows: (1) the House speaker appoints two; (2) the Senate president pro tempore appoints two; (3) the governor appoints two; (4) the House majority leader, Senate majority leader, House minority leader, and Senate minority leader each appoint one; and (5) the Insurance and Real Estate Committee chairpersons each appoint one. Members, who may be legislators, serve a three-year term and may not serve more than two consecutive terms. The appointing authority must fill any vacancy.

The bill requires the House speaker and Senate president to select chairpersons from the membership. The chairperson must schedule and hold the first commission meeting within 60 days of the bill's passage (but this may or may not be after July 1, 2007, the date by which appointments are to be made). (Apparently the members do not need to have a particular expertise or represent a particular sector. The bill does not address whether members are compensated or reimbursed for expenses.)

Beginning January 1, 2008, the commission must annually submit a report to the Insurance and Real Estate, Human Services, and Public Health committees on program implementation progress, including any recommended changes to the employer or resident contributions or state funding.

Commission Responsibilities (§ 3)

Make Insurance Available. The bill requires the commission to arrange and procure health insurance policies for program enrollees.

In doing so, it must negotiate and contract with insurers and health care centers (i.e., HMOs) authorized to do business in the state. The bill requires to commission to:

1. determine covered benefits and an enrollee's out-of-pocket cost-sharing to assure affordable access to necessary health care (presumably "medically necessary");

2. survey employer-based health coverage in New England to assist in determining the benefits and cost-sharing;

3. reimburse health care providers (but "health care providers" is not defined);

4. credential health care providers for participation in the program; and

5. issue the same Connecticut Saves card to all program enrollees (apparently a coverage identification card).

The bill allows the commission to delegate the duties of reimbursing and credentialing health care providers and preventing and managing chronic disease to a third-party administrator.

Improve Quality of Care. The commission must improve quality of care through numerous measures, including:

1. obtaining and publishing data pertinent to quality of care;

2. encouraging integrated health care systems development by incorporating procedures such as case management, registries, feedback to physicians, and a team-based approach to patient-centered care; and

3. preventing and managing chronic disease.

Reduce Health Care Spending. The commission must reduce unnecessary health care spending and control health care cost growth through numerous measures, including:

1. administrative simplification,
2. provider reimbursement policies,
3. prevention and management of chronic disease,
4. consumer quality report cards,
5. error reporting,
6. strengthening certificate of need procedures, and
7. e-health initiatives.

Establish Procedures. The commission must:

1. devise and implement systems for voluntary and automatic enrollment;
2. establish and implement policies and procedures for interstate coverage issues for state residents working or receiving health care in other states and residents of other states working or receiving health care in Connecticut (although residents of other states are not eligible for the program under the bill); and
3. arrange with the Department of Revenue Services (DRS) for employers' and state residents' premium contributions to be sent automatically to DRS through payroll withholding or other means and DRS to send those contributions to the Comptroller. (The bill does not specify an account or fund in which to deposit contributions.)

Educate Residents. The commission must educate state residents on the program and the importance of preventive care and assessments and communicate general public health messages. It must educate residents about the health insurance policies available through the program by:

1. preparing educational materials;

2. conducting informational sessions or workshops;

3. contracting with nonprofit and community-based organizations for outreach to hard-to-reach populations; and

4. training, consulting with, and reimbursing licensed health insurance brokers for help in educating residents.

Promote Information Technology. The commission must promote information technology use by (1) contracted insurers and HMOs; (2) individuals applying to, enrolled in, or seeking information about the program; and (3) people providing information to the program. It must arrange for technical support, training, and assistance on effective information technology use.

The commission must require each contracted insurer and HMO to operate a commission-certified electronic health record system that meets interoperability standards by October 1, 2007. The commission must establish the electronic health record standards by regulations. (The October 1, 2007 date may not allow enough time for the commission to develop standards and publish regulations and for insurers and HMOs to then implement compliant e-record systems.)

Adopt Regulations. The bill requires the commission to adopt regulations to implement and administer the program.

Appropriations (§§ 16-18)

The bill makes unspecified appropriations to the commission from the General Fund for FY 08 to (1) implement the program, (2) lower employer costs of providing health insurance to employees and their dependents by at least 10%, and (3) pay program reinsurance premiums.

PROGRAM HEALTH INSURANCE POLICIES

Affordable Policy (§ 4)

The bill requires the commission to make available to prospective program enrollees a health insurance policy that is affordable to most

state residents and offers specified benefits.

The policy must have an actuarial value that at least equals the sum of the actuarial value, for average New England enrollees in employer-based insurance during the previous year, of (1) all coverage, excluding dental coverage and (2) dental coverage. (The bill does not define "average New England enrollee.")

The policy must cover office visits; inpatient and outpatient hospital care; mental and behavioral health care, including substance abuse treatment; prescription drugs, including brand name and generic drugs; maternity care, including prenatal and postpartum care; oral contraceptives; durable medical equipment; speech, physical and occupational therapy; home health care; hospice services and extended care as alternatives to institutionalization; preventive and restorative dental care; and basic vision care. It must also cover, as prescribed by a physician, (1) personalized nutrition, exercise plans, and smoking cessation services and (2) examinations, screenings, and immunizations for adults and children, including well-child and –baby care, which must be provided without out-of-pocket cost-sharing.

Premium Payments and Reinsurance (§ 5)

The bill requires the commission to prospectively adjust premium payments for the policies under the program to fully compensate for any differences between the program enrollee's average risk level and the state's nonelderly (presumably under age 65) population. (It is unclear what this provisions means.)

The bill permits the commission to subsidize, during the first three years the program is implemented and within available appropriations, the cost of reinsurance premiums related to the program. The bill requires that premium payments made to the program on behalf of enrollees be used to pay for any remaining reinsurance premium cost. (Reinsurance is insurance for insurance companies, i.e., it helps spread the insured risk, thus, lessening the liability for the primary insurer.)

For subsidized reinsurance, the commission must establish risk corridors and coinsurance percentages (i.e., terms of reinsurance) based on best practices from other states.

The bill requires the commission to issue a report containing recommendations on future financing for reinsurance to the Insurance and Real Estate Committee by January 1, 2011. It also requires, if the General Assembly does not take action to the contrary by the end of the 2012 regular session, reinsurance premiums for the third and each subsequent year to be paid entirely by payments made to the program by or on behalf of enrollees.

This section of the bill presents a number of issues. It (1) does not identify the entity or entities purchasing reinsurance (presumably it is the contracted insurers and HMOs) and (2) permits subsidized reinsurance while also requiring unsubsidized reinsurance for the third year. The bill does not identify when the commission must implement the program, so it is unclear whether the 2011 and 2012 dates are appropriate. (However, section 8 requires "default" enrollment of anyone eligible but not enrolled by July 1, 2008. This presumes the program will be operational before then.)

Eligibility, Application, and Enrollment (§§ 6-8)

The bill opens the program to "eligible individuals," defined as people under age 65 who have been a state resident for at least six months. The bill permits a person other than an eligible individual to apply for coverage under the program at full cost (it is unclear if this means eligible individuals are not paying full cost, and the bill does not discuss setting the cost of policies) if the person:

1. is a state resident;

2. is age 65 or older;

3. is employed by, or whose spouse is employed by, an employer that offered insurance (presumably health insurance, and it is unclear if this applies if the employer offered a self-insured

benefit plan) on or before October 1, 2006, but no longer offers it; and

4. would have qualified to participate in insurance in effect on October 1, 2006 (but this means that the person is not eligible for the program if he or she was not qualified to participate in any employer insurance that was in effect before October 1, 2006).

The bill permits an employer to purchase full or partial coverage under the program for a retired employee who is a state resident at full cost, as determined by the comptroller. (It is unclear if this means that the comptroller is the one determining the cost of the plans issued through the program, or just the cost of coverage provided by employers for their retirees.)

Mandatory Enrollment. The bill requires an "eligible individual" who is not enrolled in the program by July 1, 2008 to be enrolled by default when:

1. DRS or the Labor Department receives a report of the person's income;

2. a state income tax form is filed that lists the person as a household member; or

3. the person seeks health care.

The bill does not indicate (1) how DRS, the Labor Department, or health care providers are to know if the person is not already enrolled in the program, (2) by what means they are to effect a default enrollment, (3) in what policy the person becomes enrolled, or (4) how to have premium contributions collected on behalf of the person. It is also unclear whether this provision violates federal HIPPA privacy rules.

BLUE RIBBON COMMISSION (§ 15)

The bill establishes a nine-member Blue Ribbon Commission to (1) study the program's effect on the cost of providing, and the

accessibility of, medical care to state residents; (2) develop recommendations for applying the program to Medicare recipients; and (3) report its findings and recommendations to the Human Services and Public Health committees by January 30, 2008. The commission terminates on the date it reports to the committees.

Commission membership includes the DSS commissioner and comptroller, or their designees, and other members appointed by 30 days after the bill's effective date. The governor, House speaker, Senate president pro tempore, House majority leader, Senate majority leader, House minority leader, and Senate minority leader each appoint one member. Members may be legislators. The appointing authority must fill any vacancy.

The bill requires the governor's appointee to be the commission chairperson, who must schedule and hold the commission's first meeting within 60 days after the bill's effective date. The bill specifies that the Insurance and Real Estate Committee's administrative staff will staff the commission (although the committee does not receive a copy of the commission's report under the bill).

HUSKY AND MEDICAID CHANGES

DSS Screening for Medicaid or Husky Eligibility (§§ 9 & 19)

The bill requires DSS to screen each person eligible for or purchasing coverage in the Connecticut Saves Health Care program to determine if they are eligible for Medicaid or the State Children's Health Insurance Program (SCHIP). The screening will also be used to determine income for purposes of establishing premium payments under the program. It requires individuals (presumably only those who qualify) to enroll in one or the other public program, unless they object.

The bill requires relevant information to be obtained through state-maintained or state-accessible data and through the individual's self-attestation to the maximum extent feasible.

The bill requires the following information to be made available to

DSS and the comptroller for purposes of Medicaid or SCHIP eligibility and establishing program premium payments:

1. eligibility and enrollment information for individuals enrolled in means-tested assistance programs other than HUSKY;

2. new hire information and quarterly reports provided to the Labor Department;

3. state income tax information that DRS maintains;

4. information showing individuals' U.S. citizenship, including information obtained from birth certificates and other vital records; and

5. federal information about new hires, quarterly earnings, Social Security numbers, immigration status, and other data pertinent to income or other components of Medicaid and SCHIP eligibility.

The bill requires the comptroller and DSS commissioner to enter into agreements with other state agencies providing or receiving information for the program. The agreements must require that:

1. the information is used only to verify or establish income or eligibility for matching federal Medicaid or SCHIP funds and

2. each agency providing information train and monitor staff and contractors who have access to the information and inform them of all applicable state and federal privacy and data security requirements.

The bill requires the DSS commissioner, within available appropriations, to develop and operate the information infrastructure needed to conduct the screenings, and take all feasible steps to maximize federal funds for this purpose. The DSS commissioner, in consultation with data privacy and security experts, must develop and

implement policies and procedures that maintain data security and prevent inadvertent, improper, and unauthorized access to or disclosure, inspection, use, or modification of the information.

The bill gives individuals about whom information is provided the right to (1) obtain, at no cost, copies of all information that must identify the agency that released the information and (2) correct any misinformation or complete any incomplete information. Individuals must be promptly informed (it is not clear by whom) if any breach of privacy occurs including any rights and remedies available as a result of the breach.

The bill makes an unspecified appropriation to DSS from the General Fund for FY 08 to develop and operate the information technology infrastructure.

Increase in Medicaid Eligibility Income Limits (§ 10)

By January 1, 2008, the bill requires the DSS commissioner to submit to the federal Centers for Medicare and Medicaid Services a Medicaid State Plan amendment to increase the income limits for Medicaid coverage for adults. DSS must extend coverage to parents, guardians, and caretaker relatives with incomes up to 300% of the Federal Poverty Level (FPL). Currently, parents and caretaker relatives of children receiving HUSKY A (Medicaid) qualify with income up to 150% of the FPL. (The bill does not specify that these adults must be caretaker relatives of HUSKY A children.)

Childless Adult Coverage. The bill also specifies that DSS may extend Medicaid coverage to any other individuals between the ages of 19 and 64 up to this same income level. They can be covered at the state's option through the amendment. Currently, only a limited number of non-elderly adults can receive Medicaid coverage, and the income limit is far below 300% of FPL (about 56%).

By January 1, 2008, the bill requires the commissioner to apply for a Section 1115 Medicaid waiver to authorize the use of SCHIP funds for individuals between 19 and 64 with incomes at or below 185% of FPL

who are not otherwise eligible for Medicaid, either "under mandatory eligibility or at state option through state plan amendment." (This appears to require the use of SCHIP funds to pay for Medicaid coverage for these adults. But, the federal Deficit Reduction Act of 2005 prohibits states from using SCHIP funds to pay for health insurance coverage for childless adults.)

The bill allows the state to meet federal budget neutrality requirements (necessary for all Section 1115 waivers) by claiming unspent uncompensated care payments to hospitals or taking other measures. But these measures may not result in the following for individuals who would have qualified for Medicaid, HUSKY, or State-Administered General Assistance (SAGA):

1. a reduction in covered services or access to care;

2. an increase in deductibles, premiums, or other out-of-pocket costs; and

3. a reduction in enforceable individual coverage guarantees.

The bill provides that if budget neutrality prevents the bill's coverage up to 185% of FPL, the coverage should be available at the highest possible lower income level.

Using SCHIP to Expand Coverage (§ 10)

The bill requires the DSS commissioner to cover individuals over the age of 18, including pregnant women, if this is necessary to access all federal SCHIP block grant funds allotted to the state. The commissioner must do this even if these individuals are not eligible for Medicaid.

Currently, the state uses SCHIP funds to cover children in families with incomes between 185% and 300% of FPL (HUSKY B), as well as 18- and 19-year-old children (HUSKY A, which is part of the Medicaid program) with income up to 185% of FPL. Younger children in families with income below 185% are eligible for HUSKY A, and their parents

or caretaker relatives qualify for HUSKY A if their income is less than 150%. Likewise, pregnant women are eligible for HUSKY A coverage with incomes up to 185% of FPL.

It appears that the bill would require DSS to cover pregnant women with higher incomes under the HUSKY B program using available SCHIP funds, which federal law allows. It is not clear how high the federal government would allow the state to set the income limit for this group.

PUBLIC HEALTH REQUIREMENTS

School-Based Health Centers (§§ 11 & 20)

By September 1, 2009, the bill requires the Department of Public Health (DPH) to expand the state's network of school-based health clinics (SBHCs) so that all public school children in the state have ready access to them. DPH must license the SBHCs, which must provide physical and behavioral health care, including dental care, with appropriate connections to other services in the state such as local health departments, community health centers, hospitals, social service providers, mental health and family service agencies, youth service bureaus, pediatricians, and other primary care physicians and adolescent medical specialists.

The bill makes an unspecified appropriation to DPH from the General Fund for FY 08 for the SBHC expansion.

Primary Care Clinics (§§ 12 & 21)

The bill directs DPH, by July 1, 2009, to establish a sufficient number of primary care clinics to supplement other primary care resources so that all state residents have ready access to necessary primary care. DPH must license the clinics which must physical and behavioral health care, and dental care. The clinics must link with specialty care providers, other primary care providers and pharmacies. Each clinic must be or operated by a (1) federally qualified health center (FQHC), (2) health center determined by DPH to be substantially similar to an FQHC, or (3) a hospital. (FQHCs are community health centers that

receive federal funding and meet specific criteria, including those governing the services they provide.)

Each primary care clinic, under the bill, must provide a wide range of primary care services and stay open outside of normal business hours to provide access to urgent, but nonemergency care.

Under the bill, physicians and other health care providers providing their services for a minimum number of hours to the clinics at a reduced rate must receive certain incentives. These include reduced medical malpractice insurance DPH offers or arranges, loan forgiveness from post-secondary educational institutions receiving funding from the state, and partial payment of educational loans. (It is unclear how the partial loan payment process would work.)

The bill makes an unspecified appropriation to DPH from the General Fund for FY 08 to establish the primary care clinics.

DPH Regulations (§ 13)

The bill requires DPH to adopt regulations implementing the SBHC and primary care clinic provisions and to establish requirements for (1) services provided by the primary care clinics and their hours of operation and (2) provision of services to primary care clinics by physicians and other providers, including the number of hours. (Presumably this is related to the incentives discussed above.)

Plans for a Healthy Connecticut (§ 14)

Beginning January 1, 2008 and biennially afterward, the bill requires DPH to publish "Plans for a Healthy Connecticut." DPH must develop these plans with assistance from state and local agencies, health care experts, and the public. Each plan must include information relating to:

1. access to essential health care;
2. health care quality;
3. health care costs;

4. data collection and analysis needs;

5. health status and health care disparities, including those based on race, ethnicity, gender, age, sexual orientation, residence, health status, diagnosis, immigration status, education, employment, English-language fluency, and other relevant factors; and

6. wellness preservation and health problem prevention.

For each of the above listed items and for any others included in the plan, the bill requires the plan to include (1) an assessment of the current status of each item in Connecticut; (2) an analysis of recent public and private efforts to address each; (3) recommendations for future public and private actions to address each item; and (4) a statement of measurable goals and objectives, with defined time frames, that reasonably can be achieved with sufficient public and private sector resources and commitment.

BACKGROUND

Related Bills

Several legislative committees have favorably reported bills broadly addressing health care access that contain provisions similar or related to those in sSB 1371. They are:

Bill Number	Committee
sSB 1	Public Health
sSB 3	Human Services
SB 70	Insurance
SB 1127	Human Services
sHB 6158	Children
sHB 6652	Insurance
sHB 7314	Labor
sHB 7375	Human Services

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 12 Nay 7 (03/13/2007)